

LONG TERM DISABILITY



EMPLOYEE BENEFITS

Claim Notice Employer's Statement

ING Employee Benefits
 P.O. Box 1290 • Minneapolis, MN 55440-1290
 1-800-328-4090

- ReliaStar Life Insurance Company of New York (outside NY)
 ReliaStar Life Insurance Company

To be completed by the Benefits Representative:

| | | | | | | |
|--|-----------------------|---|---|---|--|-----|
| Plan number | | Contract division/location | | | Employee's name | |
| Social Security Number | | Employee's home address | | City | State | Zip |
| Date of birth | Sex | <input type="checkbox"/> Married <input type="checkbox"/> Single | <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | Hire Date | Occupation | |
| Cause of disability | | | | | Effective date of LTD coverage | |
| Date last worked | Date disability began | Is disability work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes has Workers' Compensation been paid? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Has Employee been laid off? (If so, when?) | |
| Has employment been terminated? (If so, why?) Give date | | | | | | |
| List prior periods of disability in the last two years: | | | | | | |
| Has employee returned to work before submission of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No if Yes, give date | | | | How many hours per week did the employee normally work? | | |

Attach copy of participant's signed enrollment card

Is participant eligible for:

| | | |
|--|--------------------------|--------------------------|
| Unemployment compensation disability? | Yes | No |
| Sick Pay? | <input type="checkbox"/> | <input type="checkbox"/> |
| Salary continuance benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| Social security benefits? | <input type="checkbox"/> | <input type="checkbox"/> |
| Retirement income-current or past employers? | <input type="checkbox"/> | <input type="checkbox"/> |
| Auto-no Fault? | <input type="checkbox"/> | <input type="checkbox"/> |
| Other? | <input type="checkbox"/> | <input type="checkbox"/> |
| Workers' Compensation benefits? | <input type="checkbox"/> | <input type="checkbox"/> |

Include Work Compensation carrier information _____

| Date benefit terminates | Amount | Paid weekly | Paid monthly |
|-------------------------|--------|-------------|--------------|
| | | | |
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Please check appropriate box and complete spaces:

- Basic monthly earnings Monthly rate \$ _____
- Basic yearly earnings Annual rate \$ _____
- Basic contract earnings Contract amount \$ _____ Length of contract _____
- Basic weekly earnings Weekly rate \$ _____
- Basic hourly earnings Hourly rate \$ _____
- Commissions (Please attach list of commissions paid for each of last 12 months.)

| | |
|-----------------------|--|
| Date of last increase | Earnings prior to increase \$ _____ per |
|-----------------------|--|

Please complete the attached Occupational Demands form for description of employee job duties.

- Was employee late enrollee? Yes No
- Is there a layoff planned at employee's division/location? Yes No

Comments

Certification

The undersigned certifies that the above statements as to the participants are correct as reported on its records.

Name _____ Title _____

Address _____ Phone number _____ Date _____

Fraud Warnings

STANDARD:

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

In CALIFORNIA:

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

In DISTRICT of COLUMBIA:

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

In FLORIDA:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In LOUISIANA:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In OREGON:

Any person who knowingly and with intent to defraud submits an application or files a statement of claim containing any materially false or misleading information, may be guilty of insurance fraud.

In PENNSYLVANIA:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.